

CITY OF LAS VEGAS RECREATION DEPARTMENT
ABE MONTOYA RECREATION CENTER

YABL REGISTRATION FORM

PLEASE PRINT

NAME OF PARTICIPANT: _____ ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____ **MORA TEAM**
PHONE: (CELL): _____ (MOM) PHONE: (CELL): _____ (DAD)
ADDITIONAL PHONE: (W) _____ (H) _____ GRADE: _____
PRINT NAME OF PARENT/GUARDIAN: _____

RELEASE OF LIABILITY FORM

I, _____ do hereby agree to release, hold harmless, and give up any claim against the City of Las Vegas, its agents, employees, volunteers, and/or representatives. This includes any problems that may arise in the future, including damages on account of bodily injury or property damages arising in any manner out of participation in any recreation program.

I/we understand that the recreation department and the City of Las Vegas reserves the right to discontinue service at any time, to any participant/parent in the event that their behavior is one that is considered unsportsmanlike, inappropriate behavior, language, and actions as determined by recreation department staff. I WILL ABIDE BY ALL RULES AND REGULATIONS AND PARENTS CODE OF ETHICS.

I/we understand that should any injury occur during participation in any recreation program, the City of Las Vegas, its agents, employees, volunteers, and/or representatives will not be held responsible. I/we understand that by signing this form, all legal rights to hold the City of Las Vegas or its agents, representatives and staff responsible are waived.

If the participant has any **Special Needs**, or requires any special services, I/we shall inform the recreation department, in writing, of such Special Need or request of special services.

Parent/Guardian Signature

Date

NOTE TO PARENTS:

Please return this registration form with **\$40.00 payment** to the Abe Montoya Recreation Center, 1751 N. Grand Ave. Las Vegas, NM 87701.

SPORTS PHYSICAL: A SPORTS PHYSICAL IS REQUIRED TO PLAY THIS SPORT. MUST BE COMPLETED AND TURNED IN TO RECREATION DEPARTMENT PRIOR TO PARTICIPATING IN FIRST GAME. COPIES OF PHYSICAL FROM YAFL OR LITTLE LEAGUE ARE ACCEPTABLE.
ALL PAPERWORK AND PAYMENT MUST BE MADE PRIOR TO THE PARTICIPANT ATTENDING PRACTICE AND GAMES.

THANK YOU FOR YOUR COOPERATION. REC DEPT. STAFF

FOR OFFICIAL USE ONLY

FEE: \$40.00 DIVISION:

GIRLS: GRADES 3rd – 4th: _____ GRADES 5th – 6TH – 7TH : _____

CONTACT PERSON SIGNATURE: _____

PAYMENT TYPE: _____

AMOUNT PAID: _____

DATE: _____

CLERK SIGNATURE: _____

RECEIPT NUMBER: _____

JERSEY ISSUE AND RETURN

I/we understand that should any equipment be lost or damaged during the season or not returned at the conclusion of the season, I/we will be held responsible for full payment of JERSEY as follows:

Jersey \$30.00

Parent/Guardian PRINT name

Parent/Guardian SIGNATURE

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EMERGENCY MEDICAL AUTHORIZATION FORM

PURPOSE: To enable parents/guardians to AUTHORIZE emergency treatment for children who become ill or injured while under the program authority when parents are not available, or cannot be contacted.

GRANTING CONSENT: In case of emergency involving my child where I cannot be reached, I hereby give my consent to transport my child to the following medical care providers, I give any reasonable and customary medical and health care of my child deemed necessary. In case the listed medical care providers cannot be reached, I authorize appropriate medical care for my child to the listed provider, hospital, and or medical facility. This authorization does not cover any major surgery unless one other doctor/dentist concurs. Nothing in this section shall be constructed to impose liability on any city official, city employee or volunteer whom in good faith, attempts to comply with this section.

It is understood that I will be financially responsible for all emergency care.

Medical insurance provider _____ Group #: _____ Policy#: _____

Primary physician _____ Phone #: _____

Primary dentist _____ Phone #: _____

Parent/Guardian Signature: _____ Date: _____

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REFUND POLICY

REFUND POLICY: I understand that I will abide by the current Abe Montoya Recreation Center refund policy. Amount of refund will depend on the refund policy guidelines. A refund authorization request form must be filled out and submitted to Recreation office.

Parent/Guardian Signature: _____

MEDICAL HISTORY

FACTS CONCERNING CHILD'S MEDICAL HISTORY THAT MAY NOT BE INCLUDED IN PHYSICAL. All information obtained is considered confidential, except to medical provider and/or coach if need to know is required.

A SPORTS PHYSICAL IS REQUIRED TO PLAY THIS SPORT

_____ **ASTHMA** _____ **INHALER**

_____ **TETANUS (DATE)** _____

_____ **DIABETES**

_____ **MUSCULAR WEAKNESS**

_____ **HEART PROBLEMS**

_____ **SEIZURES**

_____ **BLEEDING DISORDERS**

_____ **EAR PROBLEMS**

_____ **EMOTIONAL PROBLEMS**

_____ **INFECTIOUS DISEASES**

_____ **MENINGITIS**

_____ **ALLERGIES (TYPE)** _____

_____ **HEPATITIS**

_____ **HIGH BLOOD PRESSURE**

Hospitalized for any serious illness, surgery, or accidents that would affect playing in sports program? Please explain:

_____ **USE OF CONTACT LENSES**

_____ **LONG TERM MEDICATION (LIST):** _____

Please add any additional information you wish staff, and coaches to know about your child: _____

Parent/Guardian Signature: _____

CITY OF LAS VEGAS RECREATION DEPARTMENT

COED K – 2ND GRADE AND

GIRLS YOUTH BASKETBALL LEAGUE

DECEMBER 2012 AND JANUARY 2013

REGISTRATION DEADLINE: NOVEMBER 9, 2012

PLAYER EVALUATIONS

MANDATORY ATTENDANCE!

MONDAY NOVEMBER 12 – REC CENTER GYM

5:30pm – 3rd - 4th grade

6:30pm – 5th – 6th – 7th grade

MUST HAVE PHYSICALS TO PARTICIPATE IN THIS SPORT

WEAR COMFORTABLE CLOTHING SUCH AS GYM SHORTS, WARMUPS AND MUST

WEAR TENNIS SHOES

Parents: please have gym shoes available just for practice and games

Street shoes bring in rocks, dirt and mud to gym floor

DRAFT WILL BE CONDUCTED AND COACHES WILL CONTACT PLAYERS

FOR MORE INFORMATION CONTACT RECREATION DEPARTMENT - 426-1739 or

426-3191

ABE MONTOYA RECREATION DEPARTMENT
YOUTH SPORTS PROGRAMS PHYSICAL FORM

NAME: _____

AGE: _____ **SPORTS PROGRAM:** _____

GRADE: _____

HEAD: _____ **CHEST:** _____ **HEART:** _____

ABDOMEN: _____ **EXTREMITIES:** _____

WEIGHT: _____ **HEIGHT:** _____

BLOOD PRESSURE: _____ **VISION:** _____

PHYSICIANS NAME: _____

PHYSICIANS SIGNATURE: _____

DATE: _____

PARENTS NAME: _____

PARENTS SIGNATURE: _____

DATE: _____